

OIG Report Definitions and Guidance

VOLUNTEERS	Individuals who donate their time to assist with implementing the SMP program. Volunteers are trained to perform SMP work, which is conducted during their own personal time. They do not get paid by anyone during the time they perform this work. For more information, see the “clarifications” section (page 3, outcome #1).
BENEFICIARIES	Includes the Medicare recipients, family members, caregivers, and others who receive SMP services.
VOLUNTEER TRAINING	Formal gatherings (e.g. in person, teleconference, or web conference) sponsored for the purpose of teaching or updating SMP staff and/or volunteers who in-turn will educate individuals to identify and report healthcare fraud, error, and abuse. Training reportable to the OIG does not include informal training mechanisms such as email updates or newsletters.
MEDIA AIRINGS	Any individual airing or publishing of media (e.g. print, radio, television, or electronic) to educate about Medicare/Medicaid fraud and the services of the SMP program. For more information, see the “clarifications” section (pages 3-6, outcome #4).
COMMUNITY OUTREACH/ EDUCATION EVENT	Any education activity conducted by SMP staff or volunteer that is not a Group Education Session, One-on-One Counseling session, or Media Airing. For more information, see the “clarifications” section (pages 6-7, outcome #6).
GROUP EDUCATION SESSIONS	Formal gatherings led by SMP staff or volunteers to educate recipients, family members, caregivers, and others on detecting fraud, error and abuse in the healthcare system and services offered by the SMP Program.
ONE-ON-ONE COUNSELING SESSION	A meeting between SMP staff or volunteer and an individual beneficiary and/or his or her family for the purpose of discussing or gathering information about potential healthcare fraud, error, or abuse. One-on-one counseling sessions may include beneficiary counseling, information gathering, or information sharing. For more information, see the “clarifications” section (page 7, outcome #9).
SIMPLE INQUIRY	A Simple Inquiry is brief contact initiated by a consumer and/or Beneficiary that is resolved with minimal time and research or review. Simple Inquiries typically do not require individual demographic or private personal information such as a Medicare number or information about a medical condition. For more information, see the “clarifications” section (page 8, outcome #10 and outcome #11).

COMPLEX ISSUES	Complex issues are inquiries that generally require the SMP staff or volunteer to obtain beneficiary personal identifying information and detailed information related to the issue, complaint, or allegation in order to conduct further investigation or referral. For more information, see the “clarifications” section (page 9, outcome #12).
COMPLEX ISSUES REFERRED FOR FURTHER ACTION	Complex issues referred to a Medicare representative, an investigative agency, or other appropriate organization. For more information, see the “clarifications” section (pages 9-10, outcome #13A).
DOLLAR AMOUNT REFERRED FOR FURTHER ACTION	For health care related errors, fraud and abuse issues, the dollar amount being questioned, requiring investigation or further action on the part of the SMP or other entity to which the case is referred. For more information, see the “clarifications” section (pages 10 - 11, outcome #13B).
COMPLEX ISSUES RESOLVED	A Complex Issue resolved by an SMP, a Medicare representative, an investigative agency, or other appropriate organization. For more information, see the “clarifications” section (pages 11 - 13, outcome #14).
COMPLEX ISSUES PENDING FURTHER ACTION	Complex Issues that are still being investigated by either the SMP or an entity to which the case was referred. For more information, see the “clarifications” section (page 13, outcome #15).
COST AVOIDANCE	Healthcare expenditures for which the government, a beneficiary, or other entity (e.g., secondary health insurer) was relieved of responsibility for payment as a result of the project. For more information, see the “clarifications” section (pages 13-14 and 15, outcome #16).
MEDICARE FUNDS RECOVERED	Money saved or recouped to the Medicare Trust Fund as a result of the project. This applies to money recouped through a Medicare representative, a law enforcement agency, or directly to Medicare at the provider level. See “clarifications” (pages 14 - 15, outcome #17A).
MEDICAID FUNDS RECOVERED	Money saved or recouped to Medicaid as a result of the project. This applies to money recouped through a Medicaid Fraud Control Unit, a law enforcement agency, or directly to Medicaid at the provider level. For more information, see “clarifications” (pages 14 – 15, outcome #17B).
SAVINGS TO THE BENEFICIARY	Money saved or recouped to an individual as a result of the project (e.g., co-payments, deductibles, or any other out-of-pocket expenses). See “clarifications” (pages 14 - 15, outcome #17C).
OTHER SAVINGS	Money saved or recouped to an entity other than the Medicare program, the Medicaid program, or beneficiaries (e.g., secondary health insurance), as a result of the project. For more information, see the “clarifications” section (page 15, outcome #17D).

PERFORMANCE MEASURE CLARIFICATIONS

Outcomes tracked in the Volunteer Tracking & Management Program in SMART FACTS:

#1: What constitutes an “active volunteer?”

An “active volunteer” is defined as any individual who receives training and/or donates time or resources towards the implementation of the SMP program within the reporting period. For purposes of the OIG Report and SMART FACTS, SMP volunteers are NOT individuals from partnering organizations (e.g. employees of other organizations who serve on Advisory Boards) or any individuals who are fully or partially paid through SMP funds. For example, SMP staff and subcontractors are NOT eligible to be SMP volunteers.

NOTE: *Individuals who are not volunteers according to the information above may still be able to provide match for your SMP grants. This OIG performance measure clarification document is not intended to provide guidance regarding Administration on Aging grant match guidelines. For questions about grant match, contact the Administration on Aging directly.*

Outcomes tracked in the Outreach and Education Program in SMART FACTS:

#4: What types of events constitute a “Media Airing?”

A “Media Airing” (formerly referred to as Media Outreach Activities) is defined as “any individual airing or publishing of media (e.g., print, radio, television, or electronic) to educate individuals about Medicare/Medicaid fraud and/or SMP program services.”

Examples of Media Airings are:

- Newsletters (Created by Project, and Articles for Others)
- Print Media (Articles or ads appearing in newspapers, magazines, senior guides and other media outlets, and opinions & editorials)
- Billboards
- Radio (Interviews and PSAs)
- Television (Interviews and PSAs)
- Bus Ads
- Website events

Counting Airings:

- For this performance measure, you should count **each documented time** a media effort is aired or published. If you create a PSA and send it to fifty sources but only have verification that two of them published it, your Media Airing count for that effort would be two.
- How to count the following Media Airings:
 - **Newsletter** (written by project, either for own newsletter or other organization's newsletters). Count the publication of the newsletter as ONE airing.
 - **Print Media** (Articles, Ads, Op Eds, Interviews, etc. appearing in Newspapers, Magazines, and other media outlets). Count the publication of the article, Ad, interview, etc. as ONE airing per print media venue (ex: if the same ad appears in several different magazines, each magazine is considered an individual airing). Also, count a new airing each subsequent day print media is published, if applicable. For example, an advertisement appearing in a given newspaper for 7 days in a row is 7 airings. If the same advertisement appeared in 7 newspapers for 7 days each, count 49 airings, etc.
 - **Billboard (outdoor signage)**. Count each day that an individual billboard is visible as ONE airing. To figure out how many airings one would have multiply the number of billboards by the number of days it was visible. For example: if you have 2 billboards and each is up for 30 days that would be 60 media airings.
 - **Bus Ad** Count each day that an advertisement is visible on an individual bus as ONE airing. To decide how many media airings you have multiply the number of buses by the number of days the ad was posted on the bus. For example: 5 buses have the SMP advertising on them for 30 days each, that would be 150 media airings.
 - **Facebook** Count educational postings to Facebook the same way you would a website posting (see below).
 - **Radio** (Interviews and PSAs). Enter the total number of INDIVIDUAL AIRINGS for this media activity. Note: You must have supporting documentation to back up your Radio PSA airings. Without back-up documentation, the most you can do is count one airing for each radio station that aired your PSA and enter the total.
 - **Television** (Interviews and PSAs). Enter the total the number of INDIVIDUAL AIRINGS for this media activity. Note: You must have supporting documentation to back up your Television PSA airings. Without back-up documentation, the most you can do is count one airing for each television station that aired your PSA and enter the total.
 - **Tweeting**: Count educational tweets the same way you would a website posting (see below).

- **Websites**
 - **Postings** When articles or information that meet our definition (“to educate individuals about Medicare/Medicaid fraud and/or SMP program services”) is posted to a website (yours or someone else’s), it counts as one airing.
 - **Events** (interactive web conference, hosted chat session, etc). Enter one airing for this media activity. Website *events* are one-time or limited time interactive events, e.g., web conference or seminar, hosted chat session, etc.

What does not count as an airing?

- Number of website hits or visitors (remember, we’re not counting audience reached, we’re counting airings for this outcome).
- Posting videos on YouTube. This is a means to an end. Posting on YouTube enables easy posting of educational videos to websites. You can count the posting of that video to your website, but you can’t count your upload to YouTube separately.

Frequently asked questions about counting media airings:

- **How do I count the airings of newspaper articles, PSAs, Radio interviews, etc. that are posted on the publisher’s website?**

Postings on the publisher’s website can be counted as one additional airing, since it’s a separate venue from print or a live event (even though it is the same article/interview). Count the day of posting as the day of airing. Do NOT count each subsequent day the article/interview remains live on the website as an additional airing. Articles/interviews can be left on website for weeks, months or years, much the way newspapers in libraries are available indefinitely beyond their actual print date.

- **Are media airings for Senior Guides that are printed statewide counted differently?**

SMPs are being published in Senior Guides which go out to senior centers, libraries and other locations where older adults gather throughout the state. Even though these are targeted publications, one CANNOT count the total publication as its media airings. For this type of media, each separate location the guide is distributed to would count as ONE airing. (Total distribution can be counted as dissemination to AoA).

- **What happens when there’s national media coverage of SMP that airs in my state? I did not interview for or prepare materials for the coverage, so I don’t think I can count the airings.**

You are correct. SMPs do not enter media airings related to national press (just inquiries or complex issues or any other outcomes resulting from national press). The exception is when your SMP staff, volunteers or beneficiaries are interviewed by or provide information to a reporter from the national press as part of their story. You can count documented airings of the national press article if your SMP is featured in or contributed to the article.

- **If SMPs are hanging posters and/or putting up signs to market the SMP (at SMP offices, partner offices, churches, grocery stores, etc.), does this count as an airing?**

Maybe. It depends upon exposure. If the posters are indoor (ex. bulletin boards), they do not count. If they are outdoor (such as yard signs, bus stops), they do count, BUT, they must fit the definition of media (to educate individuals about Medicare/Medicaid fraud and/or SMP program services). Count them using the billboard guidance.

- **Can you count inclusions in community calendars (online or in print) in a newspaper that gives info about an upcoming SMP event?**

Yes, but only if it fits the definition of the purpose of SMP media – meaning it must be educational in nature. For example, it has to include more than just a date a time.

- **Can I count ads seeking SMP volunteers on volunteer websites? If so, how do I count it?**

Yes, you can count it if it meets the definition of SMP media. Count according to the guidance given for website postings.

- **How can I count media efforts that I do not have documentation for?**

Unfortunately, you cannot count multiple airings for media efforts where you cannot get documentation. The effort can be counted as ONE airing. An example of this would be an interview that aired several times, but the radio station does not provide documentation of the other times it ran.

#6: How do I calculate the estimated number of people reached by “community outreach/education events?”

A “community outreach/education event” is defined as an event where general/program information and/or simple printed fact sheets are shared with, or distributed to, the public by SMP staff or volunteers. The purpose of such an event is to educate the public about health care fraud prevention, detection and reporting, and the availability of SMP services in their area. For example, some SMP programs participate in health or senior fairs or set up information booths in shopping centers in order to increase community awareness.

Estimates of the number of people potentially reached should be made by using a tick-mark for each person that approaches your booth to take materials and/or speak with an SMP staff or volunteer or by counting the number of brochures/materials distributed. You should **not** automatically count total conference, fair, or event attendance as your estimate for the number of people reached.

If, however, each participant at a conference or fair is given SMP information as part of their conference bag or materials (SMP flyers, brochures, etc.), the total number of participants at the event **can** be counted as the “estimated number of people reached”.

NOTE: *SMPs should be reminded that participants who receive one-on-one counseling are still eligible to be counted separately in that outcome. The same is true for participants who attend a group educational session offered by the SMP at a conference or fair.*

Community Event vs. Dissemination Activity: Distributing materials to locations or events that are not staffed by SMPs are not reportable as a community event to the OIG (report this as a dissemination activity to AoA). Examples: leaving materials at a library, printing the SMP phone number on pharmacy bags, etc.

#9: What constitutes a One-on-one Counseling Session?

One-on-one Counseling Session refers to an outreach session or meeting covering any topic by the SMP with one (1) individual, though caregivers or family members may be present. In a one-on-one session, the SMP provides targeted services to educate or explain beneficiary, SMP, or health care information. A One-on-one Counseling Session is considered more in-depth than a simple inquiry and is used to report incidents in which a beneficiary receives some type of individualized education from the SMP.

Proactive, one-on-one fraud education initiated by the SMP should be entered as a one-on-one counseling session (not a simple inquiry). For example, a telephone campaign to educate Senior Housing Service Coordinators about how to protect their residents from fraud would fit into this model. Each telephone call would be a one-on-one counseling session.

NOTE: *AoA reports the “number of beneficiaries educated” by SMPs each year to the OMB (Office of Management and Budget) as required under GPR (Government Performance and Results Act). The number of one-on-one counseling sessions is combined with the number of beneficiaries who attended group education sessions when reporting to OMB.*

#10: What constitutes a “Simple Inquiry?”

A simple inquiry is used to keep track of how many contacts come to the SMP with questions that have a short and simple answer. Simple inquiries are not as in-depth as a one-on-one counseling session. A Simple Inquiry can take place over the phone or in person.

Examples of simple inquiries may include:

- Caller requests information about an upcoming SMP presentation and wants further information about the presentation.
- Caller wants to obtain a Medicare and You Handbook. Your program does not stock copies of the handbook but you give the individual the phone number of the state SHIP program to obtain a copy.
- Caller wants a copy of a publication that your SMP recently released. You request the caller’s name and address to send the publication.
- Caller wants to know whether he has Medicare Part B. You explain the information on his Medicare card and respond to his question about his enrollment in Part B.
- Caller asks a question about the effective date of his Part D plan enrollment as a result of the Annual Enrollment Period.
- Caller asks for non-SMP related information. The SMP assists the caller with finding the correct answer.

#11: What constitutes a Simple Inquiry that was “Resolved?”

Were you able to answer their question or direct them to someone else who could answer their question? If so, the simple inquiry was resolved.

NOTE: *When entering simple inquiries in batches, don’t forget to also enter the number that were resolved. SMART FACTS defaults to the numeral 0. For example, if you enter 10 simple inquiries in a batch, but forget to enter how many were resolved, the system will report that zero were resolved. This will result in a low number and percentage of resolution for simple inquiries.*

Outcomes tracked in the Complex Issues and Referrals Program in SMART FACTS:

#12: What constitutes a “Complex Issue?”

Examples of Complex Issues may include:

- Caller is calling on behalf of parent who has been receiving Medicare home health services but the home health agency is unable to send sufficient staff to parent’s home.
- Caller has received door-to-door sales calls from durable medical equipment company stating that it will bill Medicaid for equipment caller does not feel that she needs.
- Caller wants to report suspected fraud or abuse by a local healthcare provider.
- Caller is from a local area agency on aging calling on behalf of a client who has billing questions about services not received by a local nursing home.
- The daughter of a Medicare beneficiary calls because she believes her father was improperly enrolled in a Medicare Part D plan.

#13A: When making a referral, what is a “Medicare representative, an investigative agency, or other appropriate organization?”

Examples of Medicare Representatives include:

- Program Safeguard Contractors (PSCs)
- Zone Program Integrity Contractors (ZPICs)
- Medicare Drug Integrity Contractors (MEDICs)
- Regional Home Health Intermediary (RHHI)
- Medicare Administrative Contractor (MAC)
- Quality Improvement Organization (QIO)
- CMS Regional Office (RO) Department of Insurance (DOI) Liaison

Examples of Investigative Agencies include:

- Medicaid Fraud Control Units (MFCUs)
- Federal Bureau of Investigation (FBI)
- State Attorney General’s Office
- U.S. District Attorney
- State Insurance Commissioner
- Local Law Enforcement
- Office of Inspector General (OIG)
- State Practitioner Licensing Board
- State Survey and Certification (Nursing Home)
- Other law enforcement or regulatory agency

Examples of Other Appropriate Organizations include:

- Adult Protective Services
- SHIP
- Area Agency on Aging
- Better Business Bureau
- Federal Trade Commission (FTC)
- Legal Services
- Medicare Plan
- Ombudsman
- Social Security Administration
- Supplemental Insurance Carriers (Medigap)

#13B: What constitutes “Total dollar amount referred for further action?”

Total number of health care related dollars in question associated with Complex Issues that are being investigated by the SMP or referred on to another entity for further investigation. No documentation required. Note: It is legitimate for SMPs to track dollars that are being questioned and investigated in-house, not just through referrals to outside entities, as long as it is health care related (such as errors on MSNs or EOBs that the SMP helps to resolve). Consumer fraud dollars should be tracked separately and not entered in the designated field for outcome 13B in SMART FACTS.

What amount on the MSN should I count as the dollar amount questioned and referred for further action?

For providers who accept assignment, you will use the “Medicare Approved Amount” for 13B. This figure encompasses both the dollars Medicare has paid and also the beneficiary’s share of the claim, giving us a full picture of the dollar amount involved. Remember, however, that when providers participate in Medicare but do not accept assignment, they can charge the beneficiary up to 15% above Medicare’s approved amount. The key is to include all potential charges involved in outcome 13B – charges to Medicare, the beneficiary, the supplement, etc. Also, if a provider violates assignment and overcharges a beneficiary, include the amount of the overcharge to the beneficiary in outcome 13B.

What about when beneficiaries are on Part C and Part D and do not get MSNs? What amount should I count in 13B?

Use the Explanation of Benefits (EOB) received from the plan to determine the entire amount of the involved claim (i.e. the amount the plan will pay plus the beneficiary's copayment or coinsurance). In these situations make sure to capture all potential charges involved in outcome 13B – charges to Medicare and the beneficiary -- just like with Original Medicare claims.

What should I do when I learn the outcome of a case and discover that the actual dollars saved or recovered are different from what was originally questioned?

Leave the original amount as-is. Outcome #13B gives the “before” picture. There are other ways of reflecting the actual dollar amount recovered or saved. If it turns out that no dollars were recovered or saved, regardless of the reason, you should still leave the original amount as-is. The same is true if the dollar amount recovered or saved was actually higher than the amount originally questioned. Outcome 13B reflects the dollar amount questioned and needing further research or investigation and is not intended to reflect the final outcome of the research or investigation.

If we didn't count dollars referred (13B) from previous years, can we count them now?

For cases received on or after the previous federal fiscal year (begins Oct 1st each year), yes. For example, if the OIG Report being retrieved is for calendar year 2011, you can enter dollars referred as far back as October 1st, 2010. Though only calendar year 2011 data will show on the OIG Report, the October – December 2010 data would be useful to AoA for reports to HHS. Dollars referred longer ago than the October prior to the current OIG Report calendar year cannot be entered. It is too late.

#14: What constitutes a Complex Issue that has been resolved?

A Complex Issue that has gone through all proper channels – whether internal or via referral – and allows the SMP to provide the beneficiary with a final determination on the disposition of the matter.

Examples of resolved cases include:

- An SMP contacts a healthcare provider to discuss a billing concern on behalf of a beneficiary. The provider acknowledges their error as a simple miscoding and indicates the beneficiary will be reimbursed. The beneficiary provides documentation to the SMP proving that they were properly reimbursed.

- A beneficiary receives a mailing for a prescription drug discount offer and contacts the local SMP. The SMP investigates the authenticity of the company making the offer and finds the company is not a legitimate vendor. The SMP reports back to the beneficiary their findings and posts a scam alert.
- An SMP receives reports that a Part D salesperson is consistently using high pressure sales tactics to get beneficiaries to sign up for a Medicare Advantage plan. The SMP refers the case to the Part D MEDIC and the state insurance division. Nine months after the original referral, the state insurance division reports back to the SMP that the salesperson's insurance license has been suspended.
- A DME company supplies a diabetic beneficiary with 5 cartons of testing strips each month and bills Medicare. The beneficiary reports to the SMP that he never uses more than 3 cartons in a month. The beneficiary has asked the DME provider to reduce the shipment to no avail. The beneficiary reports their concern along with MSN billing statements as evidence to the SMP. The SMP refers the issue on to DME MAC. The DME MAC takes action against the DME provider. 16 months later the DME MAC reports back to the SMP that the DME provider has been found guilty and must repay \$8,202 back to the Medicare Trust Fund for their tactics.
- Documentation is received to verify savings and recoveries.

NOTE: Cases with dollars entered for savings and recoveries must be closed.

When can I use the “Closed – Referral; No Response Necessary Option?”

This option is not to be used when cases are referred to CMS Program Integrity Contractors (PSCs, ZPICs, and the MEDIC) or CMS Regional Offices. These organizations will follow-up with SMPs to provide the final disposition of the case (“Action Taken” or “No Action Taken”). However, some cases referred by SMPs to other organizations may not yield a follow-up response. For example, when an SMP learns of a scam being attempted in their state, the SMP may alert the state Attorney General, the Federal Trade Commission (FTC), or the Better Business Bureau (BBB) to name a few. The SMP may not know of an actual victim of this scam, however, and may not be making a referral on behalf of a given individual. Instead, the SMP is making a referral for the purposes of protecting older adults and others; the referral is a preventative measure. This is an example of when the “Closed – Referral; No Response Necessary” option can legitimately be used.

What if I am unable to resolve a case?

When cases are referred by the SMP to an outside entity, the resolution process can take years. In those cases, resolution may be outside of the SMP's control (see outcome 15 guidance below for more information). However, complex issues that are being managed by the SMP and have not been referred to outside entities for resolution should be suspended within 12 months of receipt if nothing more can be done. Select the "Suspended" option on the SMP Activity Log for the "Current Status of the Complex Issue."

Examples:

- Beneficiary does not return a Release of Information
- SMP needs additional information to resolve the case, such as the MSN or other paperwork from the beneficiary, but beneficiary or caregiver does not follow through and/or cannot be reached.

#15: What constitutes "Complex Issues Pending Further Action?"

Research and investigation surrounding a Complex Issues often take an extended period of time and can overlap semi-annual reporting periods. All Complex Issues received by the SMP that have yet to be "resolved" should have an "Open" status in SMART FACTS. Those cases will count on the OIG Report as Complex Issues "pending further action" irrespective of when they were received.

- Cases referred to CMS Program Integrity Contractors (PSCs, ZPICs, MEDIC) may take years to investigate and resolve in court, for example. The SMP will have no choice but to leave the case open until notified later (perhaps even years later) of the outcome.
- Cases that are being managed by the SMP and have not been referred to an outside entity should not be left open longer than a year (see guidance in previous section).

#16: What constitutes "Cost avoidance on behalf of Medicare, Medicaid, Beneficiary or Other?"

All cost avoidance must be health care related. "Other" would include Supplemental Insurance payer cost avoidance.

Examples might include:

- An SMP is contacted by the manager of a HUD housing project. The manager reports that representatives from local healthcare clinics are recruiting low income seniors from the housing project and are driving them to clinics where they are told that they would be given free Ensure (a liquid nutritional supplement) as part of their Medicare benefit. A month later many of these seniors discovered that they were being billed by doctors for services that they never received. The SMP immediately begins gathering information about the clinics, obtains Medicare Summary Notice (MSN) statements from the beneficiaries, and writes up a report detailing the case. The case is referred to the CMS Representative. As a result, \$6,000,000 in fraudulent Medicare billing claims is identified. CMS immediately has the clinics shut down and invokes a Medicare Part B PIN Revocation for the 13 healthcare providers. Because CMS identified the fraudulent billing before payments were made, nothing is recouped to the Medicare Trust Fund. The \$6 million therefore represents dollars that Medicare avoided paying to fraudulent providers. CMS provides the SMP with a statement documenting the avoided costs.
- A beneficiary receives a billing statement from a provider stating they owe for a service that was never rendered. The beneficiary contacts the SMP for guidance. The SMP instructs the beneficiary not to make that payment and offer to provide assistance in contacting the provider to explain the concern. The provider acknowledges the billing error as their mistake and sends the beneficiary a revised billing statement.

#17A, #17B and #17D: What should I include as “funds recovered attributable to the project?”

Any Medicare, Medicaid or Supplemental Insurance funds documented as recovered and attributable to the project must be verifiable and include the appropriate supporting documentation. If no documentation is available, do NOT claim recoveries.

Please do not submit bills, lists of services, or other correspondence from the provider unless they directly indicate savings. If you report more than one instance of savings, please submit an itemized list that includes each of the items described above as well as the total amount of reported savings.

An example of acceptable documentation: The SMP has a copy of the questionable MSN or EOB, provided by the beneficiary or their representative. The case was referred to a CMS Representative. The CMS Representative responds with a letter verifying that the charge was in error and has been resolved.

#17C: What should I include as “savings to beneficiaries” on my report?

Savings to beneficiaries should be health care related and include situations that meet the following two criteria:

1. A beneficiary received reimbursement for, or was relieved from paying for, a health care service or product for which he/she was not responsible due to fraud, error or abuse; AND
2. The reimbursement or savings are a result of the efforts of the SMP performing its mission to reduce fraud, error and abuse in the Medicare and Medicaid programs.

Savings to beneficiaries should not include savings due to referrals for Prescription Drug Plans or other benefits such as Supplemental Security Income.

What should I submit as documentation of beneficiary savings?

Examples of documentation include:

- A cancelled or corrected bill
- A copy of a check for reimbursement of payment,
OR
- A signed statement from a beneficiary (or their caregiver/representative) as enough documentation to support savings under \$100. The \$100 threshold applies to individual complex issues, not the aggregate complex issues for the reporting period.

#16 - #17D: Cases with documented savings and recoveries should be closed

Cases with documented savings and recoveries must be closed on the SMP Activity Log (and documentation must be uploaded). If documentation is unavailable, neither savings nor recoveries can be entered into SMART FACTS for outcomes 16 – 17D. If acceptable documentation is unavailable, the dollars will be shown under Outcome 13B. If you have received partial documentation only and are still waiting for the rest, WAIT to enter the dollars into SMART FACTS. The dollars cannot be entered into SMART FACTS until you have all necessary documentation and you are ready to close the case.